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Summer greetings! I hope all you AOHP members are finding some much deserved down time at some point this summer to refresh and rejuvenate yourselves. While you are relaxing, don’t forget to make your plans to join us in Las Vegas, NV for the AOHP National Conference on October 3-6, 2012.

Please know that your AOHP Board of Directors has been hard at work. Below is an update of some recent Board endeavors:

- Maintaining fiscal responsibility.
- Supporting chapters in various ways, including quarterly Chapter Presidents Conference Calls.
- Partnering with the CDC, TJC, AIHA and Alliance to Make US Healthiest.
- Participating on conference calls with the OSHA Alliance and NIOSH IOM Educational Product.
- Collaborating with associations and groups such as ACOEM, AIHA, TJC and the Infection Control Support Association of Japan (JICSA.)
- Formalizing and increasing AOHP’s research activity.
- Completing the application submission process to MEDLINE for official indexing of our AOHP Journal.
- Analyzing data from the AOHP Staffing Survey.
- Developing a consensus statement for Sharps Injury Prevention.
- Providing AOHP representation at ACOEM’s OHC, the National Safety Conference and the International Society for Respiratory Protection.
- Embarking on the Getting Started Manual review process, with anticipated completion in late summer.
- Working on the AOHP National Conference in Las Vegas, NV.
- Obtaining ANCC continuing education approval status.
- Preparing for national elections and a bylaws revision vote beginning July 1.
- Preparing for AOHP award submissions.
- Preparing for the strategic planning process.
- Issuing several press releases, including the Getting Started Manual agreement with JICSA and CNE Providership using the American Nurses Credentialing Center (ANCC) model.
- Assessing and preparing for technology improvements, including establishing guidelines.

As you can see by this list, your AOHP Board has been very busy the past eight months, and there is more to come.

The AOHP Board is interested in member needs, accomplishments, activities and comments, so please let us know what you have been up to by contacting me at dtyler@coverys.com or AOHP Headquarters at info@aohp.org.

Enjoy your summer!
I had the honor of attending the kick-off meeting for North American Occupational Safety and Health Week (NAOSH,) held Monday, May 7 in Washington, D.C. at the Department of Labor’s Frances Perkins Building. Dr. David Michaels, Assistant Secretary of Labor for Occupational Safety and Health, spoke alongside Terrie Norris, President of the American Society of Safety and Engineers (ASSE,) and Jim Hopkins, Secretary of the Canadian Society of Safety Engineering. Since 1997, safety and health leaders from across the continent have gathered with OSHA and alliance program participants like AOHP to promote the common goal of getting workers home safe every day. This year’s NAOSH week theme, Safety, What Every Business Needs, was highlighted by the winners of ASSE’s annual children’s poster contest. “We know that a well-run business is efficient and productive when employers make sure that their workers are safe and healthy,” said Michaels. “These posters are vivid representations of an ideal work environment in the eyes of the next generation of workers.”

What’s New
During his talk, Michaels highlighted OSHA’s initiatives to prevent falls and heat injuries and also touted the agency’s recent release of the merger between the OSHA Hazard Communication Standard and the international Global Harmonization System. He specifically addressed:

Heat Related Activities: For employers with outside workers, a new outreach effort will raise awareness about the dangers of too much sun and heat. Michaels stated that OSHA – federal and state – will inspect sites to ensure that employers take proactive steps to keep workers safe in extreme heat, and to be sure that workers have been informed about the symptoms of heat exhaustion. He identified: agriculture workers; building, road and other construction workers; utility workers; baggage handlers; roofers; landscapers; and others who work outside as focus employee groups to be monitored by Compliance Safety and Health Officers (CSHOs.)

OSHA has developed heat illness educational materials in English and Spanish, as well as a curriculum to be used for workplace training. Additionally, a Web page provides information and resources on heat illness — including how to prevent it and what to do in case of an emergency — for workers and employers. The page is available at http://www.osha.gov/SLTC/heatillness/index.html. OSHA has also developed and released a free application for mobile devices that enables workers and supervisors to monitor the heat index at work sites. Supposedly, the app displays a risk level for workers based on the heat index, as well as reminders about protective measures that should be taken at that risk level. Available for Android-based platforms and the iPhone, the app can be downloaded in both English and Spanish by visiting http://s.dol.gov/RI.
Violence in the Workplace: Without a doubt, the effect of the newly released CPL on Violence in the Workplace (VITW) is evident. OSHA reports that it has already resulted in a $12,000 OSHA fine to Lakeview Specialty Hospital in Waterford, WI, for not protecting workers from workplace violence hazards. This CPL will continue to be a valuable reference manual for CSHOs conducting inspections in high risk VITW industries like healthcare. More information about OSHA’s CPL on VITW is included in Mary-Ann Gruden’s ACL Report in this issue.

Fall Protection: A big OSHA initiative – both residential and construction – expects employers to have employees trained and using fall protection. Key words for this program – Plan, Provide, Train.

National Emphasis Program for Nursing and Residential Care Facilities: Please see Mary-Ann Gruden’s ACL Report in this issue for more details.

OTHER NEWS OF INTEREST FROM THE “AGENCIES”

New Requirement: Joint Commission Accredited Healthcare Organizations Must Establish an Annual Influenza Vaccination Program for Licensed Independent Practitioners and Staff.

On May 30, 2012, The Joint Commission (TJC) released an R3 Report, a complimentary publication that provides detailed information about a July 1, 2012, requirement that all TJC accredited healthcare organizations establish an annual influenza vaccination program for licensed independent practitioners and staff. Although vaccination is the single most effective method for preventing influenza deaths and illnesses, the U.S. Department of Health and Human Services reports that vaccination rates for healthcare professionals remain below 60 percent. The R3 Report is designed to give accredited organizations a deeper understanding of the accreditation requirements that strengthen existing requirements for hospitals, critical access hospitals and long term care organizations and expands the vaccination standard to include the ambulatory care, behavioral healthcare, home care, laboratory and office-based surgery accreditation programs.

The R3 Report provides information on the elements of performance for the vaccination standard that became effective July 1, 2012, as well as specifics about three of the elements of performance that will be phased in by July 1, 2013 for certain types of organizations. In addition, the R3 Report provides the rationale for the standard, reference information, results of feedback from the field, and outstanding issues related to performance measures for vaccination rates. In addition to establishing a vaccination program, the standard will require accredited healthcare organizations to set incremental goals for meeting a 90 percent coverage rate by 2020. Organizations also will be required to measure and improve vaccination rates for staff. TJC’s standard does not mandate influenza vaccination for staff as a condition of accreditation. For more specific information, contact Kelly Podgorny, kpodgorny@jointcommission.org.

AOHP – We Care!

AOHP pins are available for purchase. You can order quantities of this pin from AOHP Headquarters. Order one for yourself or several for the staff in your department. Consider giving to members at chapter meetings.

Cost: $3.00 each, 5 = $12.00, 20 = $40.00, Quantities more than 20 = $1.80 each

No credit card payments for orders under $40.00.

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Or by Card: □ Visa □ MasterCard □ American Express □ Discover

Card Number: ______________________________________  Exp. Date: _________

Card Billing Address: ____________________________________________  CVB: ______

Name on Card: ___________________________________  Signature: ______________
Throughout 2011, AOHP continued to maintain financial stability with a balanced budget. Through long term strategic planning and annual review of budgeted items, the AOHP Board strives to maintain a positive financial position as an organization to meet the needs of our members. As we move forward into 2012, in our times of economic and environmental challenges, AOHP strives to assist members and to provide educational opportunities that are beneficial and of interest to members. We look at ways to expand membership, produce positive marketing strategies and investigate other sources of revenue to grow as an organization.

A financial review was completed for the year ending December 31, 2011 in accordance with generally accepted auditing standards. AOHP was noted to demonstrate appropriate financial management strategies.

Overview for 2011:
- Total income and expenses for 2011 remained stable.
- Publications and advertising revenue continued to be strong.
- Membership income remained stable.
- Annual National Conference income and expense ratio continued to be positive.

The following graphs depict AOHP's financial position for the year 2011. Questions concerning this report, or requests for additional information, can be obtained by contacting me by e-mail at ahook@shlhs.org or by phone at 217-258-4160. The financials are available for members to review upon request.

AOHP strives to maintain financial stability, and we welcome your suggestions as AOHP moves forward as a world class organization.

Respectfully submitted,
Anna Hook, BS RN
AOHP Executive Treasurer
Editor’s Column

By Kim Stanchfield, RN COHN-S

Thoughts of Retirement, Again

As I wrote in this column back in 2003, the thought of never giving another TB skin test or collecting another urine drug screen is appealing. And, honestly, never administering another flu shot would be a gift from heaven to me. (I absolutely dread flu shot season!) Even with the addition in 2012 that those flu shots will be mandatory and the TB tests may be blood draws does not alter the fact that I have no plans to retire, ever.

I continue to need to work. I am one of those people who must have the structure of work. I need the discipline of getting out of bed early, slathering on my make-up and driving to my office while sipping the green tea that is my “starter” now. These acts get me going and keep my brain functioning. I need the routine.

At work, I am comforted (and in 2012, challenged) by the routine. As all of you know, the “routine” in Employee Health is NEVER routine. I have ceased to be amazed by the unusual, unexpected and downright crazy things we encounter daily in our jobs. How many times have you thought “What are employees going to come up with next?” And then, you turn around and find out they are up to plenty. I would really miss that, because I take great pride in usually being one step ahead of them!

I told someone this week that I was not going to retire because people would get away with too much if I did. Retirement for me is not on the radar screen. I might miss something here at work, and I definitely believe “too much togetherness” is not good on the home front. Besides that, if I retire, who would edit your Journal? I am not willing to give up the pleasure of working with all of you.

Special thanks to
AOHP 2012 National Conference Platinum Sponsor

Hill-Rom

Many thanks to Hill-Rom for their continued support of AOHP’s national conference, to be held October 3-6, 2012.

Hill-Rom continues to extend their generosity by underwriting AOHP’s Annual Business Luncheon on October 6. This is the ninth year Hill-Rom has been Platinum Sponsor of the AOHP National Conference.

Hill-Rom provides sales, rental, service and support to the patient room environment. From beds and lifts to patient room furniture, architectural headwalls and communication, Hill-Rom offers innovative solutions to healthcare challenges worldwide. For more information, please visit www.hill-rom.com.
Association Community Liaison Report

By MaryAnn Gruden, MSN CRNP NP-C COHN-S/CM

OSHA Alliance Update
AOHP Executive Vice President Steve Burt attended the North American Occupational Safety and Health Week kick-off event, held at the Frances Perkins Building in Washington, D.C. on Monday, May 7. We thank Steve for taking time to attend the event and represent AOHP at this international celebration of occupational safety and health. The theme for this year’s observance was Safety, What Every Business Needs. A more inclusive report is featured in the Executive Vice President's column in this issue of the Journal.

OSHA Announces New National Emphasis Program for Nursing and Residential Care Facilities
National Emphasis Programs (NEP) focus on outreach efforts and inspections of specific hazards in an industry for a three-year period. On April 5, OSHA announced a new NEP for Nursing and Residential Care Facilities to protect workers from serious safety and health hazards and to reduce occupational illnesses and injuries that are common in these settings.

In 2010, according to the Bureau of Labor Statistics, nursing and residential care facilities experienced one of the highest rates of lost workdays due to injuries and illnesses of all major American industries. These are people who have dedicated their lives to caring for our loved ones when they are not well. It is not acceptable that they continue to get hurt at such high rates," said Dr. David Michaels, Assistant Secretary of Labor for Occupational Safety and Health. "Our new emphasis program for inspecting these facilities will strengthen protections for society’s caretakers."

For more information or for educational materials for employers and workers in nursing homes and residential care facilities, visit OSHA’s Nursing Home page at http://www.osha.gov/SLTC/nursinghome/index.html.

Special Issue: New Study Finds OSHA Inspections Reduce Worker Injuries While Saving Employers Money
A landmark new study by business school economists at the University of California and Harvard University confirms that OSHA's inspections not only prevent workers from getting hurt on the job, they also save billions of dollars for employers through reduced workers' compensation costs. The study, Randomized Government Safety Inspections Reduce Worker Injuries with No Detectable Job Loss, appeared in the respected scientific journal Science. Major findings of the study included: workplace injury claims dropped 9.4 percent; employers also saved an average of 26 percent on workers’ compensation costs; and the average employer saved $355,000 (in 2011 dollars) as a result of an OSHA inspection. Nationwide, the savings to employers amounted to an estimated six billion dollars. The researchers reported that benefits of the inspections were noted in both small and large companies with no adverse effect on the company's expenses of employment, sales, credit rating or firm's survival.

Blunt-tip Needles are Safer for Healthcare Workers: FDA, OSHA and NIOSH Issue Joint Safety Communication
On May 30, the Food and Drug Administration (FDA) issued a joint safety communication with OSHA and the National Institute for Occupational Safety and Health (NIOSH) which strongly encourages surgeons and other healthcare professionals to use safer, blunt-tip suture needles as an alternative to standard suture needles when suturing fascia and muscle to decrease the risk of needlestick injury.

Despite the availability of blunt-tip suture needles and the endorsement of their use by professional organizations, needlestick injuries are on the rise in surgical settings. OSHA, together with the FDA and NIOSH, has been working to increase awareness in the healthcare industry that the use of these safer needles can reduce workers’ risk of needlestick injuries by 69 percent and therefore, significantly limit workers exposure to Hepatitis, HIV and other bloodborne pathogens.
The OSHA Bloodborne Pathogens standard requires the use of safer devices, such as blunt-tip suture needles, to protect healthcare workers. For more information, visit OSHA's Safety and Health Topics page on Bloodborne Pathogens and Needlestick Prevention and the OSHA FAQ on the Needlestick Safety and Prevention Act at http://www.osha.gov/SLTC/bloodborne-pathogens/index.html.

OSHA Fines Lakeview Specialty Hospital for Inadequate Workplace Violence Safeguards at Waterford, WI, Center
OSHA has cited Lakeview Neurorehab Center Midwest, which operates as Lakeview Specialty Hospital in Waterford, for exposing employees to workplace violence at the healthcare facility and treatment center, among other violations. OSHA has proposed penalties of $12,000.

OSHA initiated an investigation following a complaint that a worker had been severely beaten and threatened by a client at the facility on Sept. 28, 2011, as well as filed a police report with the Racine County Sheriff’s Department. The result of the OSHA investigation revealed that staff members at the facility had been assaulted numerous times. OSHA has cited the employer for a serious violation of the agency’s “general duty clause” for failing to provide a workplace free from recognized hazards likely to cause serious injury or death. A second serious violation has been cited due to the lack of a lockout/tagout program for equipment with multiple energy sources. For further details, read the OSHA news release at http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=22281.

NIOSH Update NPPTL Program Stakeholder Meeting and Workshop
The fifth annual National Personal Protection Technology Lab (NPPTL) Program Stakeholder Meeting and Workshop was held at the Hyatt Regency, Pittsburgh Airport on March 20 and 21, 2012. This meeting provided a unique opportunity to communicate directly with NIOSH employees and NIOSH grant recipients about their current research projects and other workplace safety and health topics that affect four major occupational sectors. The meeting emphasized personal protective equipment (PPE) in Healthcare, Mining, Agriculture and Public Safety.

One concept that was presented was that of a “Super Course.” Ron LaPorte, PhD, University of Pittsburgh, has developed this concept, which provides local educators with the means to markedly improve local education using the Internet. The “Super Course” has been used during the H1N1 pandemic and other emergency events.

In addition to the general sessions, breakout sessions, posters, equipment displays, demonstrations of protective ensembles and respirators were available for respective industry sectors. Gordon Graham returned this year as the luncheon keynote speaker. He discussed personal protective technology, selection, use and expectations. Results of the REACH II Study were presented during one of the healthcare breakout sessions. This study analyzed respiratory protection programs in five areas of the country. Ten healthcare posters focused on various aspects of respiratory protection, including an update on the NIOSH longitudinal study examining the temporal effect on filtering-facepiece respirators. A poster was also submitted by the Respiratory Advisory Group and was well received by the attendees. A breakout session was led by Barbara Braun, PhD and Brette Tshurtz from TJC. After the participants were divided into smaller groups, each group was to brainstorm several questions and report back to the entire workshop. The ideas were recorded by TJC and will be considered for incorporation into the upcoming educational monograph that the TJC and NIOSH Technical Expert Panel will be developing. Day two of the meeting included workshops on understanding respirator fit testing and hearing loss. It was a privilege to represent AOHP at this important meeting and to continue to emphasize the need for research, especially in the area of respiratory protection in healthcare.

Update: Respiratory Protection Advisory Group
The respiratory protection group continues to meet on a regular basis by conference call. This advisory group includes stakeholder representation from the CDC/NIOSH NPPTL, the American Association of Occupational Health Nurses (AAOHN), the American Board for Occupational Health Nurses (ABOHN), AOHP, the American Nurses Association (ANA) and the Institute of Medicine Standing Committee on Personal Protective Equipment for Workplace Safety and Health.

In early May, the group distributed a survey to members of AOHP, ANA, AAOHN and certified occupational health nurses in healthcare. The goal of the survey was to identify areas of competency and educational needs related to respiratory protection. The next meeting of the group, in June, was to analyze the status of the survey results. Thank you to all of our members who responded to the survey. An abstract was accepted by AOHP to present the work of the group, including data analysis of the survey, in a poster presentation at the AOHP National Conference, scheduled for this October in Las Vegas.

Sleep Deprivation Report Highlighted
A report on short sleep duration among workers by NIOSH researcher Sara Luckhaupt, published in the April 27, 2012 issue of the CDC’s Morbidity & Mortality Weekly Report, has gained widespread attention. Both U.S. News and World Report and WebMD gave coverage to this new report, which identifies consequences of sleep deprivation, especially on workers. The WebMD article can be viewed at http://www.webmd.com/sleep-disorders/news/20120426/30-percent-workers-get-far-too-
little-sleep. For the MMWR report, visit http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6116a2.htm?s_cid=mm6116a2_w.

Fast Fact Sheets for Home Healthcare Workers
NIOSH has produced a series of six fact sheets for home healthcare workers. Topics include how to prevent violence on the job, latex allergies, musculoskeletal disorders, exposure to unsafe conditions, car accidents and needlestick injuries. The fact sheets provide practical information for this at-risk group of healthcare workers and are based on the 2010 NIOSH report NIOSH Hazard Review in Home Healthcare that can be found at http://www.cdc.gov/niosh/docs/2010-125/.

To access the fact sheets, use this link and scroll down to February 2012 for the individual topics: http://www.cdc.gov/niosh/pubs/all_date_desc_nopubnumbers.html.

Total Worker Health Link, Formerly NIOSH WorkLife Link, Launched
The NIOSH Work Health Link has become the Total Worker Health™ (TWH) link. TWH is a strategy integrating occupational safety and health protection with health promotion to prevent worker injury and illness and to advance health and well-being. Issues relevant to worker health are divided into three groups – employment, workplace and workers. NIOSH conducts research on the integration of health protection and health promotion through both internal and external avenues. Extramurally, NIOSH funds three WorkLife Centers of Excellence dedicated to ground-breaking research, translation and best practices of integrative approaches to protecting and promoting health in the workplace. An intramural program connects related work within NIOSH that will interpret and communicate current knowledge, successful approaches and challenges, and will promote the concepts and practices of total worker health to partners and stakeholders. For more information, including a newsletter, visit http://www.cdc.gov/niosh/TWH.

Update: Technical Expert Panel on Respiratory Protection Programs
The work of TJC and the CDC/NIOSH Expert Panel to examine effective respiratory protection programs continued in April with a conference call. The panel is developing a survey to solicit examples of effective components of respiratory protection programs in acute care and long term acute care hospitals. The survey will be distributed to a variety of healthcare workers, including AOHP members. As noted above, TJC conducted a breakout session at the NPPTL Stakeholder Meeting and solicited additional information and best practices from attendees that will be considered for inclusion in the educational monograph.

Injuries Before and After the Needlestick Safety and Prevention Act
In February, correspondence to The New England Journal of Medicine by Dr. Elayne Kornblatt Phillips (University of Virginia) and colleagues reported findings from a NIOSH-funded research project that the Needlestick Safety and Prevention Act contributed to the decline in percutaneous injuries among U.S. hospital workers. The findings also support the concept that well-crafted legislation, bolstered by effective enforcement, can be a motivating factor in the transition to injury-control practices and technologies, resulting in a safer work environment and workforce. Read more about this project at http://www.nejm.org/doi/full/10.1056/NEJMc1110979.

Have a safe and wonderful summer! Before you know it, we will be in Las Vegas!!!
The Tech Talk topic for this issue is all about social media. We’ve all heard of Facebook, Twitter, LinkedIn and YouTube – the “Big 4” of social media. But what about Foursquare, Loopt, digg, flickr, Google Buzz, reddit or Stumbleupon? These, too, are considered social media. So, what’s the big deal, what are some downsides and what does it mean for business? And, what’s the 4-1-1 on that AOHP Tech Group survey conducted earlier this year?

Social Media

What’s the big deal?

Classifications

If you’ve read Kaplan and Haerlein’s Business Horizons article, 2010, they classify six different types of social media: collaborative projects (Wikipedia); blogs and microblogs (Twitter or www.skinnytaste.com, found it – looks yummy); content communities (YouTube); social networking (Facebook); virtual game worlds (World of Warcraft); and virtual social worlds (Second Life.) Who knew?

Technology

The technology used by social media groups is mostly what one expects, including magazines, photos, videos, social blogs, blogs, Internet forums and podcasts.

Attributes

To paraphrase the gospel of Wikipedia, social media focuses on some or all of these seven building blocks: identity; conversations; sharing; presence; relationships; reputation; and groups.

What’s the big deal for you?

Okay, go back and re-read the previous bullets. How can social media benefit you? Say you’re an expert on hearing loss. You could mentor others on AOHP LinkedIn. That means you pretty much have all the attributes just listed. Ever been talked into giving a presentation on wellness? Maybe you want to spice it up by tying in music or massage therapy. How? Search for a group devoted to bridging those two or three topics. Work out in the “boonies?” You can connect with others who work in similar geographic circumstances. Use YouTube tutorials before giving those new subcutaneous flu vaccines.

What about using social media for disasters? The fourth floor flood or tornado warning can be instantly “tweeted” to key personnel. Say The Joint Commission just tapped on the front door. You’re gung ho to send the alert, but nobody will get your real-time tweets unless they have an account through the same social media vendor. Don’t go back to square one by sending an e-mail that may not be opened until quitting time. Sigh.

The LinkedIn Web site caters to the professional crowd. Most of us can access LinkedIn from work, so you may be able to experience it today, if it’s new to you. Sign up for a basic account, log in and you’ll see a fairly busy welcome page – all for you. Orient yourself to the screen, especially the tabs at the top. The Profile tab will allow you to customize your interests and privacy settings, review and edit. Once you have approved your hobbies or skill sets, LinkedIn will intuit which networking groups might best serve you. If you have other interests or skills to develop, type that info into the Search box and then select Groups from that drop down menu. Any search can be refined by country or even what type of group to join – corporate, professional, alumni, etc. You may join groups, but it can take several weeks to receive approval as a member. Keep track of this by selecting the Groups tab in the header. Choose Your Groups to show which memberships are pending and to which ones you belong.

It’s no surprise that AOHP is an active networking group on LinkedIn. How can you find it? Go back to the Search box, type in “AOHP” and select the Groups tab. What kind of info will you find? Just about anything job related – new opportunities, lobbying updates, training opportuni-
ties and conferences listed by AOHP or other organizations. Sprinkled throughout are questions – maybe about hearing loss. Here’s your opportunity to share your expertise.

What’s the big deal for business?
Using social media is not only cost-effective, but good strategy for business. Recruiters can cast a wider net to attract professional talent from another state or country. Post-recruiters and businesses are digging into applicants’ social media accounts. If the privacy setting is lax, they can browse through all pages and photographs. With a Friends Only setting, the prospective employee may be asked to log in during an interview. You get to play tour guide. Yikes!

Unfortunately, or fortunately, businesses that rely on social media often exploit tracking data to build client bases. Good news: if store XYZ is paying attention, they’ll know that those tacky white wedge sandals will never sell, no matter the price point. They’ll also be aware that on-line shoppers want discounts and free shipping. Bad news: you may have ads targeted for your profile that appear ad nauseam.

What are the downsides and risks?
If businesses keep tabs on virtually everything, how much privacy do you have as an employee? The latest scuttlebutt through these ears is an infringement on rights of employees. Anytime anyone publishes anything about anybody on the Internet, no matter how stringent your privacy setting, that information is tracked. Some recruiters and businesses are digging into applicants’ social media accounts. If the privacy setting is lax, they can browse through all pages and photographs. With a Friends Only setting, the prospective employee may be asked to log in during an interview. You get to play tour guide. Yikes!

There are good and bad implications. Do you really want to hire someone who posts on Facebook that a favorite activity is getting soused every weekend? Was that suggestive photo taken last month or way back when during carefree (read that morally lax) college days? As a manager, what about the employee who posted that she broke a finger while playing soccer and decided to stage a work-related injury the next day? What if a photo of you magically appeared on the Web? It’s now public – regardless of who posted it. Not a fun time if your reputation is at stake. But, if you just organized a huge successful event – you’re hired from the multitude.

Any risks using social media?
Yes. The AOHP Tech Group conducted a social media survey in early 2012. Your comments speak volumes about security and privacy settings. Approximately 65 percent of the responders belong to Facebook. This media is geared toward personal and family connections. Risk: this vendor has periodic upgrades, and with those come the unfortunate reset of most security and privacy settings. Fix: check your settings every month, and stay informed on security issues.

An overwhelming 89 percent of responders have never visited the Twitter site, so that’s one less opportunity for a burglar. What?! Risk: if you tweet or make a Foursquare entry about standing in a long movie line, your “follower” (or groupie, if you will) who has Googled your real name and found your address, may decide your house is ripe for a haul. The fact that your friend Tweeted that tidbit and did not ask permission to include your name is a social media etiquette faux pas! Fix: inform others of your preferences.

LinkedIn is the primary site for networking, according to 79 percent of AOHP responders. Even though I don’t list my given name or where I’m employed, there are uncanny suggestions to contact persons I’ve not heard from in ages. This parallels some of your comments about social media: “make more private,” “improve security,” “confidentiality.” Risks: e-mail address skimming, in my humble opinion. Fix: livable privacy settings and prudence for the wealth of information and connections. Be informed, and utilize your IT Department.

Future columns: security and privacy issues of PCs and Smartphones. Stay tuned, and update your software!
Applying Current Healthcare Research to the Practice of Occupational Health

The focus of this issue’s column is the application of current research to the everyday practice of employee occupational health as we care for the healthcare workers (HCWs) in our hospital and clinic settings. I recently attended the annual conference of the American College of Occupational and Environmental Medicine and have selected four abstracts that represent practical topics I know each of us deal with frequently. Thanks to the work of these researchers, we now have fresh, new data to consider as we conduct our work in an evidence-based fashion.

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| Blood splatter from retractable intravascular sharps | • The filters positioned around the device, while it was activated in a simulated vein, produced blood splatter up to 70/100 times  
• In seven instances (7%), blood was detected by microscopy but not by the naked eye |

**Conclusion**

- There is potential for blood splatter when using intravascular catheters with retraction mechanisms.
- HCWs may not be able to detect blood splatter and may not report a splash to mucous membranes or non-intact skin.
- This comparison reinforces the need for HCWs to wear personal protective equipment such as masks, face shields and goggles when using retractable intravascular devices.

**Reference**

Aiysa Ansari, MD, University of South Florida, College of Public Health, Tampa, FL; Donna J. Haiduven, PhD CIC (dhaiduve@health.usf.edu), V.A. Research Center of Excellence, Tampa, FL; Harmsu M. Sailhu, MD PhD, University of South Florida, College of Public Health, Tampa, FL; Lillian Collazo, MT(ASCP) CM CPH, University of South Florida, College of Public Health, Tampa, FL; Padmaja Ramalak, MSBE, V.A. Research Center of Excellence, Tampa, FL.

*Comparison of Visual vs. Microscopic Methods to Detect Blood Splatter from an Intravascular Catheter with Engineered Sharps Injury Protection (ESIP)*

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| Demonstrating return on investment (ROI) of worksite clinics | • Use of a cost-effectiveness tool demonstrates that savings were greater than cost of operating the clinic  
• The ROI magnitude was steadily between 1.7-2.0 |

**Conclusion**

- An algorithm using the following elements can objectively demonstrate ROI: avoided costs; time away from work for evaluation; and number of days off work.
- On-site workplace clinics can provide quality healthcare at a cost savings to the employer.

**Reference**

Nimisha Kalia, MD, Johns Hopkins University, Bowie, MD; David Baron, MBA, Johns Hopkins University School of Medicine, Baltimore, MD; Edward Bernacki, MD MPH, Johns Hopkins University School of Medicine, Baltimore, MD.

*Monitoring Worksite Clinic Performance Using a Cost-Effectiveness Tool*
These four studies cover a broad range of topics, illustrating the diversity of employee occupational health’s influence and responsibilities and the use of research to guide practice.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-morbidity, lifestyle and other factors in chronic back pain (CBP)</td>
<td>* Those with CBP had a significantly high prevalence of hypertension, smoking, obesity, asthma, bronchitis, sinusitis, alcohol consumption, sadness and sedentary work.</td>
</tr>
</tbody>
</table>

**Conclusion**
- Low back pain is the leading cause of work-related musculoskeletal injury. Risk factors contribute to evolution of CBP and the personal and business impact that results.
- Employee wellness programs need to go beyond physical activities to address comorbidities and unhealthy lifestyle elements.

**Reference**
Pamela Summers, MD, Health Partners/University of Minnesota, Saint Paul, MN; David Parker, MD MPH, University of Minnesota School of Public Health, Minneapolis, MN.

*Prevalence of Co-Morbidities, Lifestyle and Other Health Factors Among Working Individuals with Chronic Back Pain*

<table>
<thead>
<tr>
<th>Topic</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Managing fluctuations in QuantiFERON (IGRA) results | * IGRA results were compared with earlier study results to generate patterns in the fluctuation in values.  
  * IGRA results (8,111 HCWs/20,543 tests) showed:  
    89.5% Negative; 9.4% Positive; 0.1% Indeterminate based on TBAg-Nil values.  
  * Repeat testing showed, of all Positive tests, 55% became Negative or Low Positive. |

**Conclusion**
- Authors recommend repeating all tests >0.35 results within one to three months of initial test for all HCWs without history of TB exposure.
- Clinical treatment decisions should be made within three months of initial test.
- TBAg-Nil values that remain above 1.0 for two tests should be considered persistently infected and treated for latent TB infection.
- TBAg-Nil levels that remain between 0.7 and 1.0 for two tests should be monitored for three to six months.
- TBAg-Nil levels that remain between 0.35 and 7.0 for two tests should be considered lowly infected and continue to be monitored annually (or more often if indicated.).

**Reference**
Virginia A. Evans, MD FACEP, University of Illinois, Chicago, IL; David C. Marder, MD MPH, University of Illinois, Chicago Hospital, Chicago, IL.

*Developing a Multi-Center Database Driven Algorithm for the Clinical Management of HCWs with Fluctuations in Serial QuantiFERON (IGRA) Tests*
Tuberculosis (TB), the infectious disease caused by Mycobacteria tuberculosis (M. tuberculosis), has been a public health concern since ancient times. It is estimated that one-third of the world’s population is infected with latent TB. Infected individuals who do not develop the active form of the disease are known to have latent tuberculosis infection (LTBI), a state where the bacteria lays dormant. It is estimated that approximately five percent to 10 percent of those with LTBI will progress to active disease, frequently within two years of infection.

To effectively decrease the number of TB cases, public health entities have targeted high-risk groups with the most need for screening and subsequent treatment of LTBI. This includes healthcare workers (HCW), foreign-born persons from areas where TB prevalence is high, and persons with immune-compromising medical conditions such as diabetes mellitus, cancer and end-stage renal disease. For the past 110 years, the use of a tuberculin skin test (TST) has been the standard for LTBI screening. This form of LTBI test is an intradermally placed solution that causes a delayed-hypersensitivity reaction in those exposed or infected with M. tuberculosis, in addition to a variety of non-tuberculosis bacteria, or, potentially, those vaccinated with the Bacillus Calmette-Guérin (BCG) vaccine. Previously sensitized lymphocytes respond to the antigenic stimulus, creating an indurated wheal (palpable raised hardened area) of 10 mm or more for most and five mm or more for those who are immunocompromised. This reaction is maximal between the 48-72 hour mark, hence the “reading” of the TST two to three days after administration. Anergy, a lack of reaction by the body’s defense mechanisms when it comes into contact with foreign substances, is a concern for this test as false negative results can occur in these individuals.

Since the introduction of QuantiFERON®-TB Gold (QFT®) by Cellestis, a QIAGEN Company, in 2001, interferon-gamma (IFN-γ) release assays (IGRAs) have been offered as an alternative screening method for LTBI. In more recent years, an additional IGRA has been developed by the name T-SPOT®. TB (Oxford Immunotec.) IFN-γ plays a critical role in regulating cell-mediated immune responses to M. tuberculosis infection, and it can be measured in vitro as opposed to the in vivo TST. This advanced testing technology provides superior sensitivity and specificity in detecting LTBI. Advantages of IGRAs are that testing requires only a single patient visit to draw a blood sample, they do not boost responses measured by subsequent tests, there are experimental controls, and results can be available within 24 hours. In addition, it is not subject to reader bias, does not cause local skin reactions and is not affected by prior BCG vaccination. IGRAs also have their limitations. Disadvantages of the test include cost, as well as the potential for indeterminate results. Also, a signed consent of limitation of test is required, and the test is not indicated for those under the age of five. Regardless of the screening methodology for TB, a standard chest X-ray and questionnaire is still needed to screen for signs of active disease.

The Latent TB Answer?
Persons with LTBI have no signs or symptoms of the disease, do not feel sick and are not infectious. However, viable bacilli can persist for years or even a lifetime, and if the immune system becomes compromised, the disease can be reactivated. Although co-infection with human immunodeficiency virus (HIV) is the most notable cause for progression to active disease, any other immunocompromising factors such as renal failure, chemotherapy and long-term immunomodulating/corticosteroid drugs can cause LTBI to convert to the active, contagious form. Additionally, persons 65 years or older have a disproportionately higher rate of disease than any other age group, often because of diminishing immunity which causes reactivation of disease. Therefore, screening persons at high-risk for LTBI is a major benefit for both the patient and community.

Identification and treatment of LTBI can reduce the risk of development of active tuberculosis disease by as much as 90 percent. More than 80 percent of active TB cases in the United States are the result of reactivated latent infection. Advanced testing technologies for tuberculosis, such as the IGRA tests, can have greater accuracy and a more reliable result over the 110-year-old tuberculin skin test.

Real-World Value of IGRA Testing
Until IGRA testing became available, there was not an effective way to screen or diagnose LTBI. The screening standard employed in California is to obtain an initial X-ray and a questionnaire on positive testers. For subsequent years,
of the Association of Occupational Health Professionals in Healthcare

The individual completes a questionnaire, and an X-ray would be performed only if symptoms develop. It was incorrectly assumed that those foreign-born persons who had BCG vaccines would always test positive on TST. It was also incorrectly assumed that the person vaccinated would have life-long immunity against TB. In reality, the BCG vaccine is about 80 percent effective and lasts about 15 years. Because of these misconceptions, many foreign-born persons continued to reside in high-density TB areas, even as their vaccines’ effectiveness diminished, and in some cases have converted to the latent form of TB infection.

IGRAs have provided an opportunity to screen significantly more people, regardless of previous TB status, and by identifying those with LTBI can thus have a major impact in reducing TB activation and eliminating the cost of treatment and exposure screening.

The CDC recommends IGRA testing for initial screening, and all new hires within the California healthcare community may be given an IGRA diagnostic blood test. This allows a quicker result and saves the employee three visits to the clinic. IGRA testing is also offered to all past positive healthcare employees. The exception is those individuals who have a past history with confirmation of TB infection. This group of people typically has taken anti-TB medication and will continue to have a positive IGRA test. This group continues to be an outlier for testing and can only be assessed on symptoms and radiographic evidence. The CDC also encourages re-testing of “low-likelihood” individuals who test positive on an IGRA test. 10

Although IGRAs have proven a major step forward in improving LTBI screening, switching from the TST to an IGRA in California may not be straightforward. According to the Program Flex in California, a healthcare facility converting to IGRA testing of employees generally follows a total adaptation—screening all new and current employees with an IGRA and eliminating the TST. The cost to convert to 100 percent IGRA screening would increase laboratory fees by ~$50,000 - $100,000 annually based on 2,500 people. Rather than convert all employment screening to an IGRA, Mercy Medical Center, Redding, CA, has chosen a hybrid alternative to the Program Flex—screening foreign-born, BCG-vaccinated and populations at higher risk with QFT, and the rest of the employees with a TST. This strategy has proven effective in enabling the use of an IGRA while maintaining financial stewardship of occupational health costs. Finally, in the event of M. tuberculosis exposure, the IGRA could be used instead of TST for follow-up screening. This is done typically at initial exposure and six to eight weeks later. The CDC has advocated the use of IGRA in this manner and finds it a comparable method of screening to the TST. 10

References


Curtis Chow, FNP PA-C, is a dual-licensed Nurse Practitioner/Physician Assistant specializing in Occupational Medicine, Ergonomics, Safe Patient Handling, and Health and Wellness. He serves as Employee Health Coordinator for Mercy Medical Center in Redding, CA and provides care to a three-hospital service area treating employees for injuries, addressing inflection control issues, and leading Safe Patient Handling, Industrial Ergonomics, and Health and Wellness. Chow has been a member of AOHP Northern California Chapter since 2007.

AOHP + Las Vegas = Education, fun.

Register for the 2012 Conference today at https://www.aohp.org/conference2012
Thoughts from a Fellow Occupational Health Colleague

By Karen Karwowski, MSN RN Ed CHSP

As children, we were told we could be anything we wanted to be. We pass that message on to our children, as well. As nurses, we are so fortunate to have that be true, as we can still practice in such a wide variety of areas and venues: pediatrics, behavioral, ICU, occupational (of course!), ambulatory, home care – the list is quite expansive. And, if we feel we need a change for whatever reason, we have the unique ability to change fields and practice in another area.

I have worked in a number of fields in my 24+ years as a nurse, and I am so blessed to be practicing as an occupational health nurse for more than seven years now. Our specialty is quite a calling. We are caring for those who take care of the entire population our communities serve who need sick or well care. Think about that for a moment. Without us providing services every day to our colleagues, how many more sick days off would employees have? How many more unattended or under-managed injuries would people be working with? How many staff members would catch preventable, communicable diseases? How many people would receive the outreach and help they may not even realize they need? We have an awesome responsibility to our colleagues, and I am so proud to be part of the team that can provide what each one needs, as we all should.

I feel equally blessed to be part of AOHP. This organization has so much to offer its members and is unique in that our national component has a “small town” feel to it. I am not knocking any organization, as all have their good points, but what I have found with AOHP that makes a difference for me is the benefits that come from being part of this organization and how it has impacted my professional practice. The ability to network at the local level at our bi-monthly meetings is of immeasurable help. I also can pick up the phone or send an e-mail at any time to a colleague to get a quick answer to a “burning question.” Our national conference is top-notch for both topic content that is relatable to everyday practice as well as the invaluable networking on a national level.

Everyone I have met at both the local and national levels has been so encouraging and empowering, from our Executive Leadership Team to members from other states that I just meet in a conference break-out session. There are no strangers; only dear friends who just don’t know one another’s names yet. That attribute is quite special among our membership, and we should celebrate and cherish it. If it weren’t for the encouragement and empowerment I received from my local members, I would never have run for chapter officer and grown in those roles. I am doing things I would never have thought possible. I never imagined I would present a poster at a national conference, and now I am honored to be (gasp!) a speaker for the third year at our conference. Now, I am writing this article for our Journal – this is all truly beyond anything I had ever thought I would or could do. Who knows what is next? But, as we all were told as children, we can do and be anything we want. So, I want to pass that message on to each of you again and encourage you to engage in your local chapters as well as our national organization. You, your clients, all of us, and AOHP as an organization, will reap huge benefits from it.

Karen Karwowski, MSN RN Ed CHSP, is the Nurse Manager of Employee Health & Safety at Henry Ford Hospital & Health Network and West Bloomfield Hospital. She has been a member of AOHP since 2006.
The AOHP Board of Directors reviews position statements on an annual basis. In April 2012, the board approved replacing the previous Ergonomics Statement with a broader statement that addresses Injury and Illness Prevention Programs. A complete list of AOHP Position Statements can be found at http://aohp.org/pages/tools_for_your_work/position_statements.html.

**AOHP Reviews Current Position Statements**

**POSITION STATEMENT**

**Injury and Illness Prevention Programs**

The Association of Occupational Health Professionals (AOHP), as the national leader for occupational health professionals in healthcare, strongly supports the creation and implementation of injury and illness prevention programs within all healthcare settings. These programs involve a proactive process to find and fix work place hazards before healthcare workers are injured. These programs have the ability to not only decrease injury and illnesses, they also have the ability to change the culture of the work environment including increased productivity and quality, reduced turnover, reduced costs and increased employee satisfaction.

The basic elements of a program include:

- Management leadership
- Worker participation
- Hazard identification and assessment
- Hazard prevention and control
- Education and training
- Program evaluation and improvement

These elements are individually important and collectively are interrelated and interdependent.

Each healthcare setting is different. These elements can be developed in a manner that will meet the needs of the organization.

Occupational health professionals (OHPs) in healthcare are well-suited to initiate and lead these efforts in their organizations. If the OHP is not the leader of the program, he/she is definitely a stakeholder that needs to be a member of the injury and illness prevention team.

Reference: US Department of Labor, Occupational Safety and Health Administration, Injury and Illness Prevention Programs, White Paper, January 2012

Review Date: 
Revision Date: 
Supersedes Policy Dated: 
Effective Policy Date: 04/12
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Web-Based Employee Health Software with NO Per User License Costs. That’s Something to Smile About!

Eliminate paper forms, take surveys online and get instant reports. Simplify your Flu program. Access practice guidelines and clinical decision support tools. IT’S THAT EASY.

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- True Web-based SaaS Platform, Minimal IT, Secure
- Role-based Access: Keeps Your Data Safe
- Data Feeds Populate Information Automatically
- Automated Text and Email Alerts
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Registration open at https://www.aohp.org/conference2012

All AOHP members are encouraged to consider attending the annual educational conference this October in Las Vegas.

Why?
Vegas is a great place to visit, but the conference itself is the real reason to attend. The education provided that enhances work practice, keeps you updated on current laws, rules and expert recommendations is the main benefit.

How?
Even with limited outside training budgets, there are many ways members can get assistance to attend. Here are a few suggestions:

- Apply for an AOHP Sandra Bobbitt Scholarship
- Check with colleagues and share a room
- Utilize frequent flyer miles
- If you live within driving range, sign out an employer vehicle and share the ride with colleagues.
- Garner manager support. Submit a proposed work plan based on the topics at the conference. Address in your work plan what you will implement on your return and how that will save money and improve safety and regulatory compliance at your facility. Stress that it is NOT where you are going but WHAT you are going to learn and bring back.

Every AOHP Annual Educational Conference has the same goal: motivate, update and educate the members. 2012’s conference continues the same goals and also happens to be held at a most desirable, FUN location. This is a WIN-WIN for all!!
The 2012 National Conference will be held at:
Caesars Palace
3570 Las Vegas Blvd, Las Vegas, NV 89109
Phone: 702-731-7110
Special Group Rate - Palace Tower Deluxe: $179/night

The grandest of Las Vegas Hotels, Caesars Palace, is famous worldwide for its magnificent beauty and impeccable service. This majestic Las Vegas hotel offers a 129,000 square foot casino, 26 restaurants and cafes, sprawling gardens and pools, a world-class spa, and the renowned Colosseum spotlighting world-class stars.

NIOSH Director Dr. John Howard to Keynote AOHP’s 2012 Annual National Conference
John Howard, MD MPH JD LLM, will deliver the keynote address Workforce Health and the Healthcare Industry, on Thursday morning, October 4 at the AOHP 2012 Annual National Conference in Las Vegas, NV. He will discuss current issues in occupational safety and health, including challenges related to the 21st Century American workforce, the promotion of worker health and safety, and the discovery and impact of imminent changes in health insurance. Dr. Howard is the Director of the National Institute for Occupational Safety and Health (NIOSH) in the US Department of Health and Human Services.

Below are some of topics will be offered at the conference:

- 2012 Legislative Update
- Action Plans for Identifying and Supporting the Chemically-Impaired Employee
- Age-Friendly Health Care Environments
- Analysis of a Successful Risk Reduction Program
- Antineoplastic drugs in healthcare
- AOHP Court – Rides Again
- Behavior Change in the Workplace
- Ceiling lifts
- Establishing the Value of Occupational Health Nurses’ Contributions to Worker Health and Safety
- Use Social Media To Improve Employee Health Communication
- Hazardous Chemicals in Healthcare
- Health and Wellness in a Hospital Setting
- How To Read Recent Research and Incorporate it into Practice
- IGRA TB Testing
- Managing Potential Violence in the Workplace
- Discussion Panel - Mandatory Influenza Vaccination of Healthcare Workers
- Occupational Health Nursing 2010 Practice Analysis Report
- Professional Passion in a Season of Renewal
- Reducing Needlestick Injuries and the Cost of Workmen’s Compensation
- Research on improving Employee Health in the Healthcare sector
- Respiratory Protection
- Safe Patient Handling Program
- Sharps Hotline
- Solution To Rising Workers Compensation Costs
- Strategies and Business Planning For Results
- Stress, Burnout And Compassion Fatigue
- The Role of Health Promotion in Reducing Employee Injuries
- Tuberculosis Update
- Utilizing an Analysis of the Physical Requirements of Jobs Throughout Employment
- Violence Prevention

Vegas has a ton of things to do and sometimes you just don’t know where to start. From ultimate pool parties to concerts to the world’s best cuisine, Las Vegas has redefined entertainment. On this website http://www.visitlasvegas.com/how-to-vegas/, they’ll show you where to start, what to see and what to do. Whether you’re a regular or have never been, they’ll show you How To Vegas. If you do it right, you can enjoy a little bit of everything - or a lot of whatever you love the most.

See you in Vegas!
AOHP Executive Board Member Spotlight

Beverly Hagar, BSN RN COHN-S, Region One Director

How long have you served on the AOHP Board of Directors?
I have served almost two years, in the role of Region One Director.

When did you join AOHP?
I first joined our local area networking group, HEHN (Hospital Employee Health Nurses,) in the early 90s. That group then joined the national AOHP sometime in the mid 90s, and we became a local chapter of AOHP. We chose AOHP as our networking group because it was most closely aligned with our mission and goals, and we felt it would have the best networking potential.

What attracted you to run for a Board position?
I served as an officer on the local level for many years. I served as secretary and president in my local chapter. I was impressed with the activities and knowledge of the Board members at national meetings and with the management group. I felt this was a great way to expand my knowledge base and activity in AOHP.

What do you see as your greatest challenge in your current Board position?
The greatest challenge we have faced in my region is the struggle to keep small chapters viable. I had one chapter that had not met for several years when I came on the Board, and another that had only held sporadic meetings. Both chapters were very small and struggled with recruiting volunteers for officer positions. Ultimately, these chapters were not able to meet the requirements of the national bylaws and had to disband.

What do you think is the greatest strength of AOHP?
AOHP is doing a great job of positioning itself as a resource on a national and soon to be international level. The leadership is doing a great job ensuring that we have a voice with OSHA, NIOSH and other groups. The national conference provides a great opportunity to network and learn, and the local chapters do a great job as well, at providing educational opportunities for members.

What, personally, is your greatest reward serving on the AOHP Board?
The Board is comprised of some very delightful and educated individuals. They have a wealth of knowledge, and I learn so much every time we meet. I have recently been facilitating the Chapter Presidents quarterly meetings, and it has been a wonderful experience to network with that group and to listen to all of the innovative ideas they share with each other.

Our AOHP members would love to learn some more about you personally. Would you please share a “small look” into your “regular work and life” ...outside AOHP?
Professionally, I am proud to be part of an organization that was the first in the United States to mandate Influenza Vaccination for its employees. I was a member of the flu team from its inception and have had the opportunity to speak multiple times locally, nationally and internationally on the subject. This past year, I conducted presentations in California, Idaho, Washington and Alaska. That has kept me very busy! I also am a single mom and have a beautiful 25-year-old daughter. I love movies, travel (I have been to many countries, but not all of them,) reading and gardening. This year, I am working on trying to fill up a brand new rock retaining wall.

What advice would you give to AOHP members to encourage volunteerism within the organization?
I think volunteering for the organization is a great growth experience! Much like employee/occupational health, it seems the more I know, the more I realize I don’t know. Over the years, the people I have met through the organization have been so wonderful, mentoring me and guiding me along. I don’t know what I would have done without that support. I only hope that I can give back just a portion of what has been shared with me.
AOHP 2011 Online Staffing Survey Results

By MaryAnn Gruden, MSN CRNP NP-C COHN-S/CM

Abstract
An online membership staffing survey was conducted with the goal of reporting current staffing patterns and making recommendations for staffing in occupational health (OH) offices in a healthcare setting. Responses came from facilities of all sizes that provide services to a variety of healthcare personnel (HCP). The results of the survey demonstrate that there are factors affecting the size of the OH services staff that extend beyond the scope of this survey. As a result, it is difficult to make specific recommendations for staffing patterns. However, an unexpected finding was that managers with graduate degrees were more likely to work in larger facilities and were more likely to be certified.

Introduction
An online survey was developed to obtain current information on staffing patterns in various healthcare OH settings. Prior to this survey, limited staffing information had been gathered in previous AOHP Membership and Needs Assessment Surveys, which had been conducted every five years. Currently, there are no definitive standards or benchmarks for staffing in OH offices in healthcare settings. Members were sent a worksheet to gather the needed data before completing the online survey. The survey was distributed in January 2011. Of the 1,096 members surveyed, 281 (27%) responded. Due to the possibility that multiple AOHP members could work in the same OH office, the survey requested that only one questionnaire per facility be completed by a designated member. In addition, not all respondents answered all questions.

Number of Licensed Beds
Respondents were asked to identify the number of licensed beds in their facility (Table 1.) The majority of the 261 respondents (57%) worked in facilities with 101 to 300 licensed beds.

<table>
<thead>
<tr>
<th>Number of Licensed Beds</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50</td>
<td>31</td>
</tr>
<tr>
<td>50 - 100</td>
<td>26</td>
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<tr>
<td>101 - 200</td>
<td>51</td>
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<tr>
<td>201 - 300</td>
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<tr>
<td>301 - 400</td>
<td>32</td>
</tr>
<tr>
<td>401 - 500</td>
<td>23</td>
</tr>
<tr>
<td>&gt;500</td>
<td>41</td>
</tr>
</tbody>
</table>

Types of Healthcare Personnel Receiving Services
All respondents provided services to employees, and nearly all provided services for other types of HCP whether or not they were employees (Table 2.) There was no correlation between the type of HCP that received services and the number of beds in the facility.

<table>
<thead>
<tr>
<th>Types of Healthcare Personnel</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>100%</td>
</tr>
<tr>
<td>Students (nursing, medical, respiratory, radiology, etc.)</td>
<td>97.9%</td>
</tr>
<tr>
<td>Volunteers</td>
<td>99.6%</td>
</tr>
<tr>
<td>Medical staff (non-employed)</td>
<td>99.3%</td>
</tr>
<tr>
<td>Other</td>
<td>99.3%</td>
</tr>
</tbody>
</table>

Occupational Health Service (OHS) Staffing Patterns
The definition of full time equivalent (FTE) was included in the worksheet to aid respondents in a consistent calculation for the number of FTEs in a variety of job categories. The categories included both salaried and hourly registered nurses (RNs), licensed practical nurses/licensed vocational nurses (LPNs/LVN)s, nurse aides (NAs), physicians (MDs), nurse practitioners (NPs), physician assistants (PAs), clerical staff and other types of staff. In Table 3, “Average Nursing FTEs” included RN, NP, LPN/LVN and NA responses. The “Average Other FTE” category includes MDs and PAs. In addition, there were 77 vacancies identified by respondents. There were plans to fill 30% (23) of those vacancies at the time of the survey.

A question of interest during survey development was whether there was a correlation among the number of HCP served, the number of FTEs budgeted, and average hours of work per week in the OHS office. Analysis of the responses indicates that the overall average ratio of OHS FTEs to number of HCP receiving services was 1:1,026. Significant correlations were found between FTEs and number of OHP receiving services (r = .796, p < .001,) FTEs and average hours of work per week (r = .842, p < .001,) and number of HCP receiving services to the average number of hours worked in the OHS office (r = .631, p < .001.)

The size of the hospital (number of licensed beds) only explained about 22%
of the variation in the number of FTEs. The association between total number of HCP served and OHS office size was approximately 29%. Combined (51%), these associations indicate that there are other unknown variables that impact the size of the OHS staff in a given facility. These unknown variables were not able to be identified in this survey.

Day-to-Day Manager

Given the variety of functions and services that can be provided in the OH professional role, other questions of interest for the survey were what type of OHP managed the OH office and was the manager a salaried or hourly employee (Table 4.) Of the respondents, RNs, including NPs, managed approximately 84% of the offices, and 77% of these nurse managers were salaried employees.

Highest Degree Held by Manager

Of the 255 respondents, the most common degree (Table 5) held was a bachelor’s degree (43.5%). Both associate degree or less and graduate degree respondents equaled respectively 28.2%. Graduate degree managers were found significantly more often in larger hospital settings when compared to managers with associate degree education or less (Kruskal-Wallis, \( X^2 = 6.739, p = .034 \)). There was no difference in frequency between associate degree prepared and bachelor’s degree prepared managers. On average, graduate degree managers serviced significantly more people (M = 4,524) when compared to associate degree (M = 2,752) or bachelor’s degree (M = 3,091) managers (ANOVA; F [2, 252] = 5.816, p = .003). On average, graduate degree managers serviced significantly more FTEs (M = 4.65) when compared to associate degree (M = 2.60) or bachelor’s degree (M = 3.05) managers (ANOVA; F [2, 252] = 5.816, p = .003.) For the average number of hours worked, graduate degree managers had correspondingly more hours worked in the department (M = 168.71) than associate degree managers (M = 88.99,) but there was no difference between bachelor’s degree managers (M = 122.97) and either associate degree or graduate degree managers (ANOVA; F [2, 252] = 6.371, p = .002.)

Manager Certification

Certification was held by 37% (104) of the managers (Table 6.) Multiple certifications were held by 19 managers. The most common certification among RNs was by the American Board of Occupational Health Nurses (ABOHN.) Graduate degree managers were significantly more likely to be certified (58%) than either bachelor’s degree managers (37%) or associate degree managers (29%), but there was no statistical difference between associate degree and bachelor’s degree managers (Mann Whitney U; z = -3.554, p < .001.) Likewise, the number of certifications was significantly higher for graduate degree managers (M = 0.65 per manager) than associate degree managers (M = 0.33 per manager,) but no statistical difference between bachelor’s degree managers (M = 0.48 per manager) and either associate degree or graduate degree managers (ANOVA; F [2, 252] = 4.556, p = .011.)

### Table 3

<table>
<thead>
<tr>
<th>Total Number of Healthcare Personnel Served</th>
<th>Number of Respondents (N=257)</th>
<th>Average Total FTEs</th>
<th>Average Nursing FTEs</th>
<th>Average Clerical FTEs</th>
<th>Average Other FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200</td>
<td>14</td>
<td>1.13</td>
<td>0.89</td>
<td>0.07</td>
<td>0.17</td>
</tr>
<tr>
<td>200-600</td>
<td>19</td>
<td>1.00</td>
<td>0.80</td>
<td>0.09</td>
<td>0.11</td>
</tr>
<tr>
<td>601-1200</td>
<td>50</td>
<td>1.57</td>
<td>1.26</td>
<td>0.15</td>
<td>0.17</td>
</tr>
<tr>
<td>1201-1800</td>
<td>32</td>
<td>1.41</td>
<td>1.12</td>
<td>0.24</td>
<td>0.05</td>
</tr>
<tr>
<td>1801-2400</td>
<td>24</td>
<td>2.78</td>
<td>1.66</td>
<td>0.59</td>
<td>0.54</td>
</tr>
<tr>
<td>2401-3000</td>
<td>27</td>
<td>3.20</td>
<td>2.20</td>
<td>0.60</td>
<td>0.34</td>
</tr>
<tr>
<td>3001-4000</td>
<td>19</td>
<td>3.07</td>
<td>2.30</td>
<td>0.56</td>
<td>0.21</td>
</tr>
<tr>
<td>&gt; 4000</td>
<td>72</td>
<td>6.84</td>
<td>4.51</td>
<td>1.45</td>
<td>0.89</td>
</tr>
</tbody>
</table>

### Table 4

<table>
<thead>
<tr>
<th>Who is Manager</th>
<th>Frequency</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN - Salaried</td>
<td>165</td>
<td>58.70%</td>
</tr>
<tr>
<td>RN - Hourly</td>
<td>53</td>
<td>18.90%</td>
</tr>
<tr>
<td>Not Indicated</td>
<td>25</td>
<td>8.90%</td>
</tr>
<tr>
<td>NP - Salaried</td>
<td>16</td>
<td>5.70%</td>
</tr>
<tr>
<td>Other - Salaried</td>
<td>11</td>
<td>3.90%</td>
</tr>
<tr>
<td>LPN/LVN - Hourly</td>
<td>4</td>
<td>1.40%</td>
</tr>
<tr>
<td>Other - Hourly</td>
<td>3</td>
<td>1.10%</td>
</tr>
<tr>
<td>LPN/LVN - Salaried</td>
<td>2</td>
<td>0.70%</td>
</tr>
<tr>
<td>MD - Hourly</td>
<td>1</td>
<td>0.40%</td>
</tr>
<tr>
<td>NP - Hourly</td>
<td>1</td>
<td>0.40%</td>
</tr>
<tr>
<td>MD - Salaried</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>PA - Hourly</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>PA - Salaried</td>
<td>0</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

### Table 5

<table>
<thead>
<tr>
<th>Type of Degree</th>
<th>Frequency</th>
<th>% of Total*</th>
<th>% of Known*</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN/LVN</td>
<td>2</td>
<td>0.7%</td>
<td>Associate’s or Less 28.2%</td>
</tr>
<tr>
<td>Diploma</td>
<td>24</td>
<td>8.5%</td>
<td>Bachelor’s 43.5%</td>
</tr>
<tr>
<td>ADN</td>
<td>46</td>
<td>16.4%</td>
<td>Bachelor’s 43.5%</td>
</tr>
<tr>
<td>BSN</td>
<td>91</td>
<td>32.4%</td>
<td>Bachelor’s 43.5%</td>
</tr>
<tr>
<td>Bachelor’s - Other</td>
<td>29</td>
<td>7.1%</td>
<td>Bachelor’s 43.5%</td>
</tr>
<tr>
<td>MSN</td>
<td>40</td>
<td>14.2%</td>
<td>Graduate Degrees 28.2%</td>
</tr>
<tr>
<td>MBA</td>
<td>2</td>
<td>0.7%</td>
<td>Associate’s or Less 28.2%</td>
</tr>
<tr>
<td>MPH</td>
<td>4</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>Master’s - Other</td>
<td>22</td>
<td>7.8%</td>
<td></td>
</tr>
<tr>
<td>DO</td>
<td>0</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>MD</td>
<td>0</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Doctorate</td>
<td>4</td>
<td>1.4%</td>
<td></td>
</tr>
</tbody>
</table>

*Note: % of total includes all 281 respondents; % of known includes 255 respondents who provided information.
Discussion
Analysis of the survey revealed the following:
• Facilities of all sizes provided services to various types of HCP, and there was no correlation between the size of the facility and the type of HCP served.
• Significant correlations were found between: FTEs and number of HCP served; FTEs and average hours of work per week; and number of HCP served to the average number of hours worked in the OHS office. The ratio of FTEs to HCP served was 1:1,026.
• In addition to the number of licensed beds and number of HCP served, there are unknown variables that impact the size of the OHS staff.
• Salaried RNs are the most common type of manager.
• Managers with graduate degrees were more likely to be found in larger facilities and were more likely to be certified.

Conclusion
AOHP continues to encourage consideration of the following points in the Getting Started in Occupational Health in the Healthcare Setting Manual when evaluating and justifying staffing needs. These points include but are not limited to:
• What services are offered?
• What is the total number of HCP being served?
• Are services provided for healthcare personnel other than employees?
• How long does it take to provide each service? This can be determined by identifying the services provided and the average length of time needed to provide the service, including documentation. Monthly statistics can be used to assist in this process.
• What are the additional responsibilities of the department? Consider committee work and other programs such as infection prevention and control, respiratory protection, injury prevention, and case management for workers’ compensation or leaves.
• What level of clerical support is needed?
• Is recordkeeping manually maintained, computerized or a combination of both?
• What are the roles and level of functioning of the current staff?
• What are the hours/days of operation?
• What regulations – local, state or federal – impact services that are provided?

Each healthcare organization has its own unique needs that influence staffing patterns in the OH office, whether it is a stand-alone facility or a healthcare system. We are only beginning the journey to identify the additional variables, beyond facility size and number of HCP served, that impact staffing levels. Identifying these variables and how they impact staffing may be the most surprising part of the journey.

Special thanks to Donna L. Agan, EdD, for her assistance and patience in preparing the data analysis of the survey. She is Director, Operations Integration, Scripps Memorial Hospital, San Diego, CA.

References
Return to Work
– Managing the Return to Work Issues After a Concussion

By Elizabeth M. Pieroth, PsyD, ABPP

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In Memory

Pamela Warren-Mishowski
7/13/1957 – 4/16/2012

The AOHP Michigan chapter is saddened by the loss of member Pamela Warren-Mishowski on April 16, 2012. Pam was the beloved wife of Joseph Mishowski, and the loving mother of Paula, Brandon and Brent. She was an employee of Oakwood Healthcare System in Dearborn Michigan for thirty one years, where she most recently held the position of Manager of Employee Health Services. She was an active member of the AOHP Michigan Chapter since joining in 2005.

Pam is greatly missed by her colleagues, and is remembered as an outstanding boss, nurse, and coworker. She is also remembered as a practical joker, talented, creative, gentle, caring woman who was loved by all who knew her. She was devoted to her family and work. We were blessed to have Pam as part of our lives. She had a big heart and was always willing to help others and put everyone before herself. Those who knew her will miss her dearly, yet her spirit will never be forgotten and will be in our hearts forever.
Return to Work
– Just Stuck! Managing Ambivalence and Resistance to Going Back to Work, Part 1

By Kenneth Mitchell, PhD
Return to Work
– Staying Stuck! The Case Manager’s Predicament, Part 2

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